EXHIBIT 3

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Health Care's *Colossus*

How UnitedHealth harnesses its physician empire to squeeze profits out of patients




By Bob Herman , Tara Bannow , Casey Ross , *and* Lizzy Lawrence

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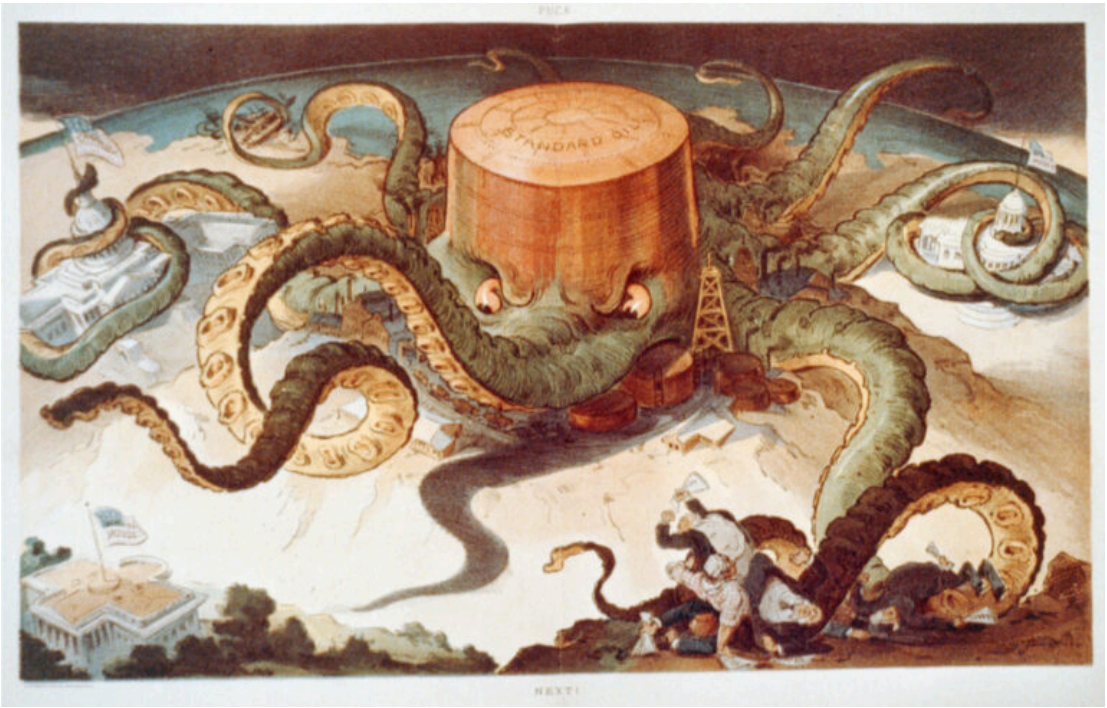
This is the first in a periodic series about how UnitedHealth Group wields its unrivaled physician empire to boost its profits and expand its influence.

UnitedHealth Group started out as a small, Minnesota health insurance company and has since morphed into a modern-day Standard Oil, exerting unmatched dominance over health care in the United States.

It's no secret that UnitedHealth is a colossus: It's the country's largest health insurer and the fourth-largest company of any type by revenue, just behind Apple. And thanks to a series of stealthy deals, almost 1 in 10 U.S. doctors — some 90,000 clinicians — now either work for UnitedHealth or are under its influence, more than any major clinic chain or hospital system.

But behind those statistics, there's a lot UnitedHealth doesn't want you to know. A STAT investigation reveals the untold story of how the company has gobbled up multiple pieces of the health care industry and exploited its growing power to milk the system for profit. UnitedHealth's tactics have transformed medicine in communities across the country into an assembly line that treats millions of patients as products to be monetized.

Central to these tactics is UnitedHealth's unrivaled leverage over physicians, whose diagnoses help determine how much private insurers get paid for covering older adults. Dozens of former doctors and employees at UnitedHealth medical practices told STAT how they became enmeshed in UnitedHealth's strategy to make their patients seem as sick as possible. Doctors said the company had a fixation with medical coding to generate more revenue — encouraging clinicians through bonuses and performance reviews to identify more health problems in patients, even if those conditions seemed dubious.



An early 20th century editorial cartoon depicts a "Standard Oil" tank as an octopus with tentacles wrapped around the steel, copper, and shipping industries, as well as a state house, the U.S. Capitol, and the White House. *Udo J Keppler/Library of Congress*

By controlling doctors, UnitedHealth can lean on them to practice in ways that benefit the insurer, and use its insurance arm to funnel cash back to its clinicians — similar to how Standard Oil amassed power as both the buyer and seller in oil refining. Through these efforts, and by adeptly navigating the Medicare Advantage payment system, UnitedHealth has squeezed potentially tens of billions of extra dollars from taxpayers over the past decade, according to STAT estimations based on federal data. The relationship

between UnitedHealth's insurance company and physician practices is the focus of an ongoing Department of Justice antitrust probe.

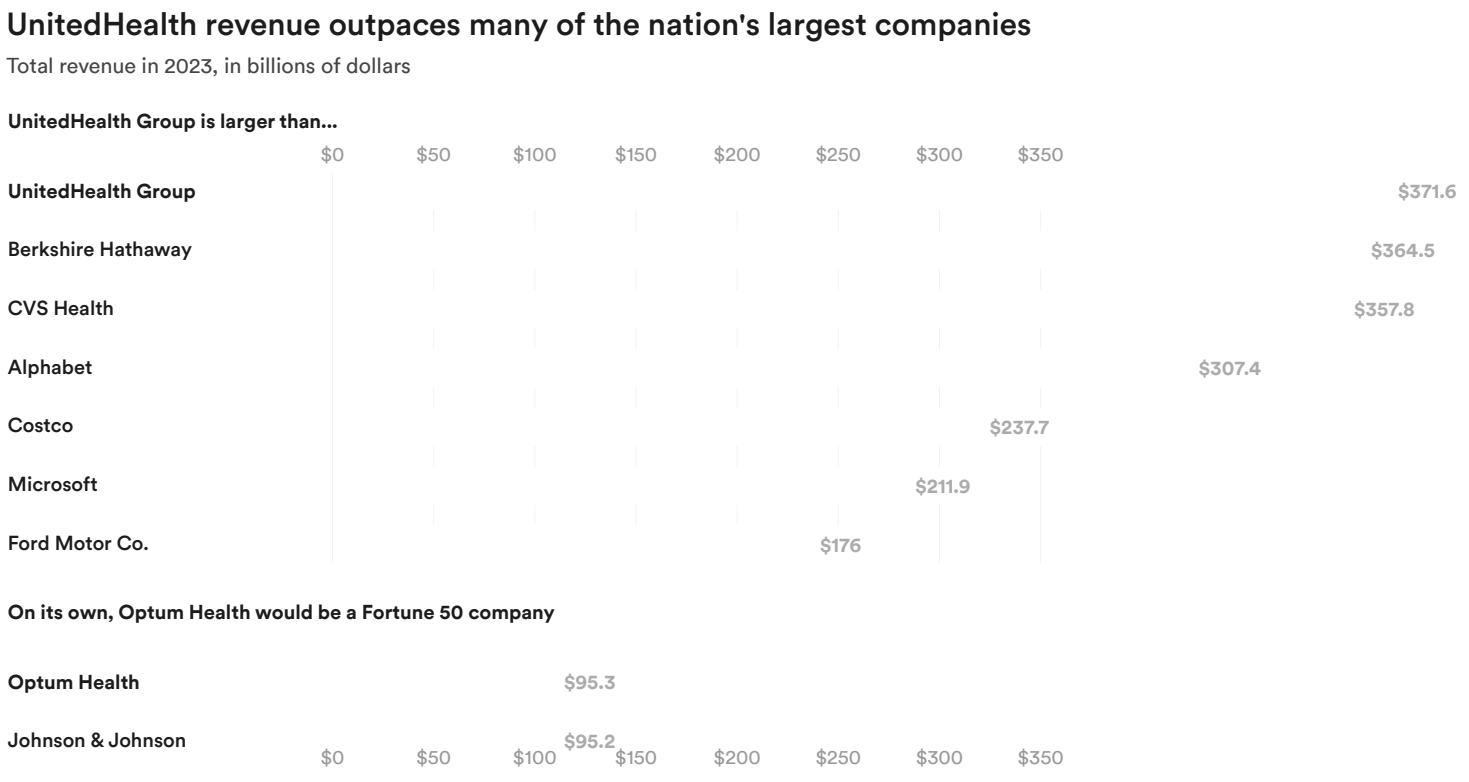
Doctors interviewed by STAT said they were initially seduced by the company's sales pitch that it would be hands-off and help them provide high-quality care, but they quickly became disillusioned. UnitedHealth has required some physicians to see as many as four patients per hour, a difficult task if any of those patients are new to a clinic, they said. Patients, meanwhile, are wondering why their doctors are rushing through their appointments — if they can get seen at all — and have expressed alarm when concerning diagnoses pop up in their medical records, many of which were never mentioned by their physicians.

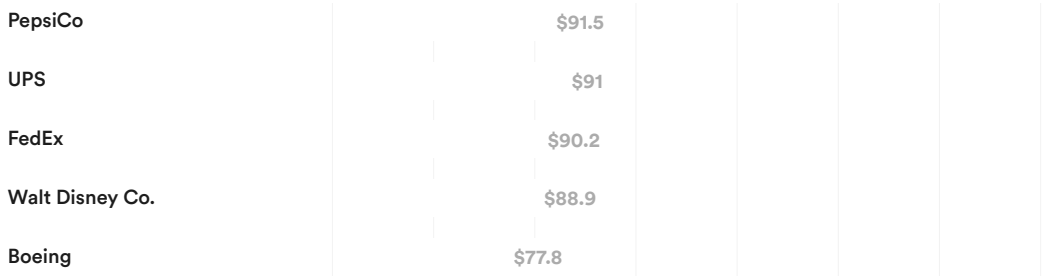
Susan Baumgaertel experienced the shift firsthand. She is an internal medicine physician who spent 25 years — almost her entire career — at The Polyclinic, a large multispecialty group in Seattle. After UnitedHealth took over in 2018, Baumgaertel said the company pressured her and her colleagues to code patients for certain conditions, including some that the doctors didn't think applied. She quit in 2021.

"We were not truly caring for patients anymore," Baumgaertel said. "We were just micromanaging their care to bring in money. It just felt so unconscionable."

She's become an unofficial therapist for dozens of her colleagues who still work at UnitedHealth practices, dispensing advice and words of comfort over hours-long walks or coffee dates. Recently, Baumgaertel was on the phone with another physician who worked at a UnitedHealth-owned clinic at the time, and had just pulled up in front of her house.

"She was crying in her car. She said, 'Susan, I can't leave. I'm the breadwinner. I have to have insurance. My husband is a stay-at-home dad,'" Baumgaertel recalled. She could hear her friend's kids knocking on the car window. "She felt trapped. I hear this over and over again."





Optum Health includes its physician groups, surgery centers, post-acute services, telehealth, home health, and bank.
Chart: J. Emory Parker/STAT • Source: Fortune, company filings

STAT's reporting is based on interviews with more than two dozen current and former UnitedHealth doctors and executives conducted over the past six months. STAT also spoke with health policy experts and patients, examined court records, and read UnitedHealth's 600-page medical coding bible. Many of the UnitedHealth doctors and executives, and even some patients, asked for anonymity — expressing concerns the company could take them to court, derail their careers, or alter their care.

Accounts from clinicians like Baumgaertel challenge UnitedHealth's stated rationale for its increasing control over health care. The company says owning medical groups, while also being the insurer, will allow for better preventive care that is "value-based." Why wait for people to show up in the emergency room with serious, costly issues when you can keep an eye on them in the clinic and intervene earlier?

UnitedHealth declined to make executives available for interviews and did not answer a detailed list of questions. In a statement to STAT, spokesperson Eric Hausman said the company's "providers and partners make independent clinical decisions, and we expect them to diagnose and document patient information completely and accurately in compliance with [federal] guidelines. We provide training and other practice support to providers because it leads to better care management, coordination, and patient follow-up. Regulators routinely audit this documentation."

UnitedHealth Group headquarters in Minnetonka, Minn. *Jenn Ackerman for STAT*

From the start, the takeover of physician practices by the nation's largest health care company has been carefully choreographed.

UnitedHealth's leadership team is filled with people who have stayed at the company a long time, and have enriched themselves by doing so. Those executives have leveraged a system that has put patients' medical charts at the center of how companies get paid. They have lobbied the government over policies that further entrench UnitedHealth's market power. Several executives have held powerful federal health care positions of their own. And they have capitalized on the government nudging more older adults to enroll in privatized Medicare Advantage plans. UnitedHealth's clinics and outpatient centers now provide care for about 103 million Americans, according to the company's own estimates.

In 2007, at a Wall Street conference in a posh midtown Manhattan hotel, UnitedHealth's then-CEO Stephen Hemsley telegraphed that UnitedHealth — already a rapidly expanding health care company — saw itself as much more than just an insurer. "I would ask you to begin to think about UnitedHealth Group and the construct of its business, its capabilities, its reach in the marketplace, as a health care system unto itself," he said.

That same year, UnitedHealth struck a deal for an insurance company that owned Southwest Medical Associates, a group of clinics located throughout Nevada — the company's first large medical group. This happened as the health care industry was on the cusp of its biggest transformation since the advent

of Medicare nearly five decades earlier — changes that would ultimately reinforce UnitedHealth's new direction and spur it to double down on doctors.

The Affordable Care Act, which President Barack Obama signed into law in 2010, limited the amount of profit insurers could make on health insurance. That encouraged many insurers to branch into other lines of business where profit wasn't capped — such as providing medical care. The law also sought to tweak how doctors and hospitals got paid by adding incentives for keeping patients healthy instead of just paying for every visit or procedure. That meant, of course, more collaboration between providers and insurers.

The result was consolidation across all corners of the industry: Insurers bought insurers. Hospitals bought hospitals. And doctors — many of them overwhelmed by new rules around documentation and using electronic health records — flocked to hospitals, private equity firms, and insurers that could handle the administrative burden. UnitedHealth's Optum subsidiary was one of the biggest players in the feeding frenzy, bringing tens of thousands of doctors under its umbrella. Today, less than half of the country's doctors work at physician-owned practices, according to the American Medical Association.

As for UnitedHealth, Hemsley, along with former Optum CEO Larry Renfro and several other top executives, positioned themselves as architects of the company's physician empire. Hemsley still serves as UnitedHealth's board chair and has his own investment firm. Renfro, who led Optum from its reorganization in 2011 until 2018, now works at UnitedHealth's venture capital firm.

While UnitedHealth expanded in patient care, it also grew its dominance in Medicare Advantage, the alternative to traditional Medicare that is run by private insurers and now covers more than half of all Medicare beneficiaries. UnitedHealth has had the biggest slice of enrollment in the program for more than a decade, growing from 20% of Medicare Advantage enrollees in 2010 to almost 30% in 2023.

That simultaneous growth was no accident. Medicare Advantage insurers depend on clinicians to enter diagnosis codes into patients' medical records. Those codes turn into risk scores that explain how sick the patient is and, in turn, how much money the government pays their insurer for their medical care.

Medicare Advantage insurers have gamed the system by excessively coding their members, resulting in massive overpayments to the companies. Overpayments based on coding alone are expected to total $50 billion this year, more than the Department of Justice's entire budget, according to the Medicare Payment Advisory Commission, a group of experts that advises Congress on Medicare. Since 2007, MedPAC estimates Medicare Advantage insurers have reaped $217 billion in coding overpayments from the federal government.

As the country's biggest Medicare Advantage insurer and its biggest physician group, nobody is better positioned to extract massive sums from the program than UnitedHealth. The company is still facing a federal lawsuit alleging it continued to collect government money based on millions of patient diagnoses it knew were incorrect. UnitedHealth has disputed the allegations and continues to contest them in court.

While UnitedHealth operates in a completely different industry than did Standard Oil, they have unmistakable similarities, starting with their ambitions to stealthily expand. When Standard Oil was acquiring competing oil refineries in the 1860s and 1870s, the conglomerate did so with little trace. Under its founder John D. Rockefeller, Standard Oil scooped up nearly all the refineries in the Cleveland area, but few newspapers were aware of the growing monopoly.

"It had all been accomplished in accordance with one of Mr. Rockefeller's chief business principles — 'Silence is golden,'" journalist Ida Tarbell wrote in "The History of the Standard Oil Company."

UnitedHealth rarely announces its takeovers of physician clinics and outpatient centers. In part, that's because the acquisitions are small compared with its overall size and therefore don't have to be disclosed to financial regulators. It also has downplayed the number of physicians it controls through employment and other financial agreements.

Of UnitedHealth's 90,000 physicians, 10,000 are employed, and the others are affiliated through "value-based care arrangements," the company said. It's unclear what the financial parameters of those affiliations are, and UnitedHealth declined to clarify. In a statement, UnitedHealth's Hausman said, "The vast majority of the physicians we work with are independent and choose to work with us," reiterating CEO Andrew Witty's remarks to Congress.

But UnitedHealth has clearly targeted specific, important medical groups and outpatient surgery centers in markets where it also has the most Medicare Advantage enrollees. The company's strategy goes like this: If UnitedHealth could get more of its insurance members to go to its own physicians, the company would get to pay itself with money that previously would have gone out the door.

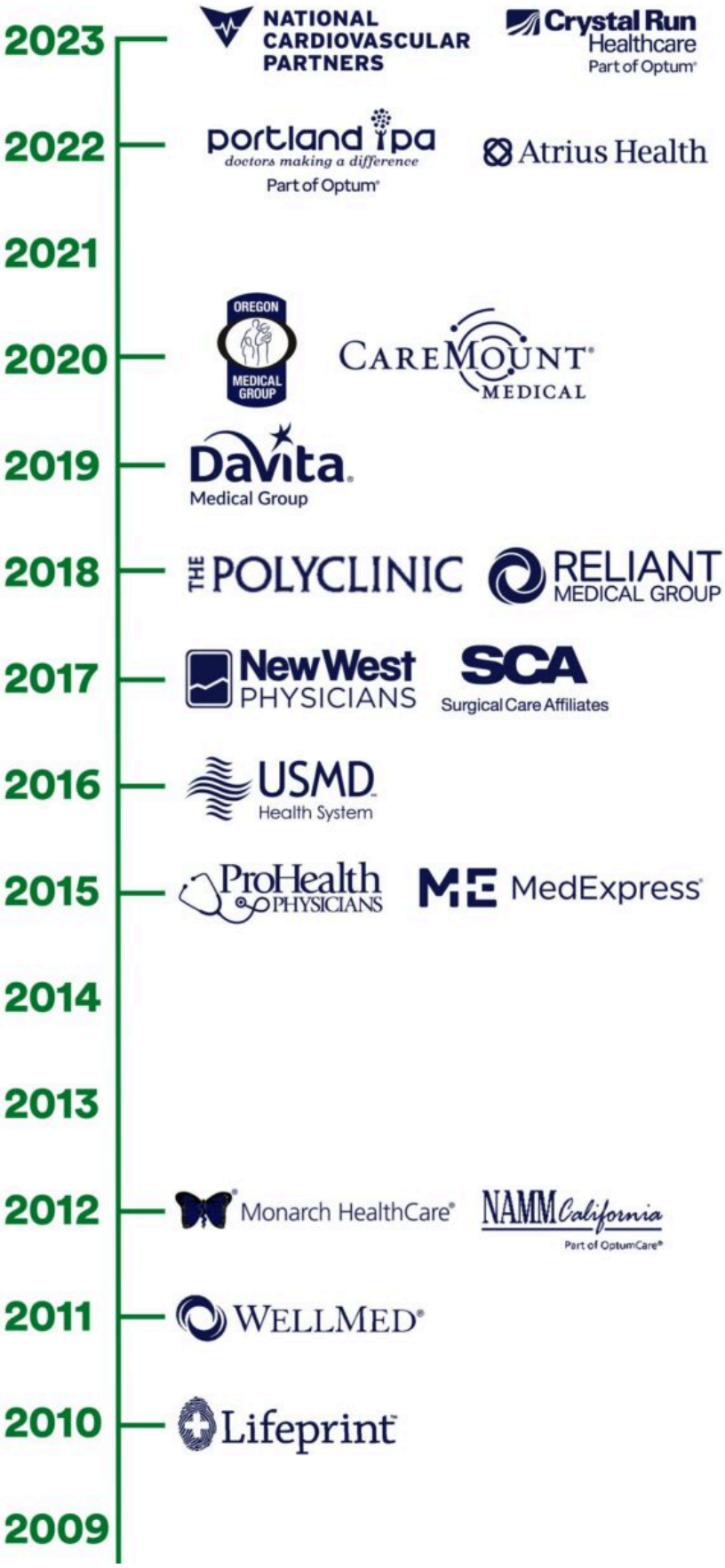
"Controlling the physicians is incredibly lucrative for maximizing risk-coding payments. It's hard to overstate just how lucrative this can be," said Hayden Rooke-Ley, an Oregon-based attorney and senior fellow for health care at the American Economic Liberties Project. He has written about the risks of insurers owning physician groups. "This is the singular explanation for why insurance companies are getting into the business of care delivery, particularly of primary care."

At the core of amassing its doctor empire was luring physicians. UnitedHealth quickly found the surest approach: Money, and a lot of it.

Some groups needed cash to invest in new electronic health records and other technology, or were facing financial distress. Physicians who bought into the idea of less wasteful care and more prevention opted to sell to UnitedHealth rather than to private equity or their local hospital systems. Plus, physicians nearing retirement were looking for a golden parachute, and UnitedHealth in some cases dangled huge sums of cash, according to multiple former physicians who sold practices to UnitedHealth and other employees.

"The doctors wanted the moolah, especially the older physicians," said a former employee of a UnitedHealth clinic in the western U.S.

Timeline of UnitedHealth's biggest physician acquisitions



Six former UnitedHealth doctors said that when UnitedHealth took over medical groups, nothing would immediately change. But as the weeks and months passed, UnitedHealth would begin to overhaul their schedules: They were expected to see more patients, perform more physicals, and conduct more annual wellness visits. Some said they were required to see three or even four patients per hour.

In 2022, UnitedHealth acquired Atrius Health, then the largest independent doctor group in Massachusetts. Eleanor Hobbs, an urgent care physician, soon began dreading her shifts because her new corporate owner required her to see patients every 20 minutes. Previously, she saw a patient every 30 minutes. Hobbs, 76, had planned to work longer, but instead retired earlier this year.

“When I retired, my feeling was: I feel just like an Amazon warehouse worker, where all I’m doing is 20 minutes, 20 minutes, 20 minutes, 20 minutes,” Hobbs said. “Just do it. Don’t ask how the patient feels about it. Don’t ask what kind of a moral injury it feels like to me. It was awful.”

The pressure to treat patients as if they were fields of medical codes to be harvested, instead of people who have complex histories, soon followed. More than a dozen former doctors and employees from seven different practices nationwide described how UnitedHealth pushed its clinicians to document as many ailments as they could by offering bonuses or reviewing the performance of those who were not coding as much as their peers.

“If your numbers aren’t great, they meet with you individually. It just felt like at every avenue possible, you were reminded of it,” a former Polyclinic provider said.

Nine clinicians told STAT they were instructed to document conditions they didn’t believe applied. Six former UnitedHealth physicians said the shift has been most apparent since the Covid-19 pandemic, as they’ve been encouraged to catch up on coding after patients stayed at home instead of going in for routine checkups.

“It’s very frustrating to me as a physician to see something that was really intended to be a way to pay primary care doctors to do good, preventive risk assessment,” a physician formerly at UnitedHealth’s New West Physicians group in Colorado said of risk scores and coding. “And it’s turned into this coding vehicle where, ‘How do we drop as many codes as we can?’”

Potentially improper coding routinely came up in the same categories, such as peripheral vascular disease and chronic kidney disease, former UnitedHealth doctors said. One study from 2022, crafted by UnitedHealth’s own physician researchers, shows that UnitedHealth’s physicians coded Medicare Advantage patients as having lung disorders, vascular conditions, and kidney disease at more than two times the rate of those in the traditional Medicare program.

A separate review of provider data suggests the trend was broader than just UnitedHealth. It shows the rate of vascular disease testing and diagnosis across providers in a national dataset more than doubled

between 2018 and 2023 among patients aged 50 and older. The analysis, based on electronic health record data and conducted by the health analytics company Truveta for STAT, also showed the rate of testing and diagnosis decreased in spring 2024, after Medicare eliminated a particularly lucrative code for patients with peripheral vascular disease without complications.

Part of the issue is the difference in the federal programs. Traditional Medicare pays doctors for each service they provide, while the government pays Medicare Advantage insurers based on how sick their members are, as determined by codes from doctors. Health policy experts say traditional Medicare undercounts older adults' ailments. Coding and documentation also can be more of an art than a science at times, especially for complex patients who have a lot of medical problems. But within Medicare Advantage, conditions that can be open for interpretation can be exploited.

"There are probably a subset of diagnostic codes that are kind of squishy. They're kind of subjective. They're kind of game-able," said Chris Pope, a senior fellow at the Manhattan Institute, a conservative think tank, who has studied Medicare Advantage coding.

Four doctors told STAT it was common to get panicked calls from patients. They wanted to know why their online medical charts said they had chronic kidney disease or vascular disease even though their doctors hadn't mentioned it during their visits. When Baumgaertel got those calls, she said she always tried to tell patients the truth, as uncomfortable as it was: I don't really think you have that condition, but I'm supposed to code you as having it so that I get paid more.

Primary care physician Susan Baumgaertel said after UnitedHealth took over The Polyclinic in Seattle, the company pressured doctors to code patients for certain conditions, including some they didn't think applied. "It just felt so unconscionable." *Courtesy Susan Baumgaertel*

"It was almost to the point of being embarrassing," she said. "These are people I've known for a long time, and they're like, 'Susan, what's going on?'"

Doctors said that UnitedHealth medical directors and administrators pressured them to increase codes for a variety of different ailments, even if they thought those codes didn't fit patients' conditions. As one example, more than a half dozen clinicians said UnitedHealth used an unreliable device to screen nearly

all of its Medicare Advantage patients for peripheral arterial disease as a way to boost vascular disease diagnoses.

Another example is chronic kidney disease. It's normal for people's kidney function to decline as they age, but five doctors said UnitedHealth pushed them to code for that condition even if they felt the patients' diminished kidney function was appropriate for their age and unlikely to cause harm.

"The number of elderly patients I had who had legit panic episodes when they went to their chart and found out they had chronic kidney disease," a former Polyclinic doctor said. "I'd have to have this whole conversation with them about like, 'No, your kidney function is actually not that abnormal for your age, but because of this coding thing, blah blah blah.' That was awful."

Daniel Weiner, a nephrologist at Tufts Medical Center, said many older adults meet the technical definition of having chronic kidney disease based on tests that examine their kidney function. The problem is there's a limited number of codes for chronic kidney disease that cover a large group of people.

"There are clearly financial reasons to code people with chronic kidney disease, as some of these patients have extremely complex medical issues, but others, with the same code, are far healthier," he said.

Nick Jones, a primary care physician who joined Oregon Medical Group in Eugene just before UnitedHealth bought the practice, said the inaccurate code he saw most frequently in patients' records was long-term management of insulin. In some cases, he said, this code was applied to patients who received insulin once to lower their blood sugar before a surgery, but who never needed the drug again.

Jones said he finally got fed up when the Oregon Medical Group's electronic health record started making it mandatory that doctors attest to whether patients' Medicare Advantage codes had been checked off before they could close out a visit. The system gave the option to deny the codes, but that was more labor-intensive because it required an explanation for why the codes were wrong, he said.

UnitedHealth would regularly host educational sessions where company representatives spent hours teaching Oregon Medical Group doctors how to code Medicare Advantage patients, Jones said. He found it frustrating because the sessions never covered new research into specific conditions or resources available for patients, like nutritionists or case managers.

"I don't give a damn about what reimburses for what," said Jones, who now runs a practice called Clear Health Direct Primary Care. "I'm just going to code what I addressed during that visit."

Even surgeons were roped in, according to one who used to work at The Polyclinic.

"It just didn't make a lot of sense for a surgeon to talk to patients about chronic illnesses that didn't necessarily have a lot to do with their presenting complaint," he said. "We're not frankly specialized or qualified to do it."

Nine doctors reported being rewarded with bonuses if they met UnitedHealth's coding expectations. One former Polyclinic surgeon said it could be upwards of $30,000 per year. But if doctors didn't comply, it

affected their entire department, that surgeon said. UnitedHealth declined to respond to questions about whether it encouraged coding through bonuses and performance reviews, and whether it encouraged doctors to use specific codes that exaggerated patients' conditions.

"So are you going to be the turd — sorry — are you going to be the doctor, who is not compliant and causing your partners to lose thousands of dollars? No. And ultimately, that's what got me to be compliant," the former Polyclinic surgeon said. Eventually, he and his colleagues left for a different medical group.

Top UnitedHealth executives have gushed to investors over the past 15 years that thoroughly documenting patients' conditions is an untapped line of recurring revenue. UnitedHealth has become such an expert on the topic that it sells a coding bible to the medical community for $165.95. The 592-page book explains how the government's payment system works and provides advice on how to "capture" more conditions.

The tips give a sense for how the company views coding and documentation: as a way to distill patients to a series of numbers and decimals that translate into big dollar figures. Coders are taught that every 0.1 in coding equates to $1,000, more or less, from the government per year.

Does a patient have diabetes? That adds 0.166 to the risk score, according to the government's 2024 risk adjustment system, equating to $1,700 in annual Medicare payments. Congestive heart failure? That's another 0.36 to the patient's score, or $3,600. Severe obesity, cocaine use, Medicaid eligibility — all descriptors that lead to more money.

Some may assume Medicare Advantage insurers push for more documentation of these diagnoses because of a "desire to make a profit," UnitedHealth's 2024 coding guide reads. "This is a half-correct assumption," the guide concedes, before saying coding also ensures companies get enough money from the government to cover care.

UnitedHealth's guide emphasizes how coders should scour physicians' notes to see if there are other illnesses that aren't being captured. For example, it says doctors should mark down a patient's cancer diagnosis when they come in for an unrelated issue like a high cholesterol reading if that patient's records show they are actively seeing an oncologist and on cancer medication.

Richard Lieberman, a medical coding expert who helped develop the government's risk adjustment system, said there is "far too much gaming of risk coding, but also of documentation." Big companies like UnitedHealth have insulated themselves from more sweeping government investigations by justifying everything in medical charts, even if the diagnoses are wrong or based on flawed diagnostic tools, he said.

"It becomes sort of like a 'Catch Me If You Can' kind of scenario," Lieberman said. "Only when you get audacious is your number often up."

One doctor who used to work at UnitedHealth's WellMed practice in Florida told STAT that managers set a troublesome expectation that risk scores could only go up, not down. UnitedHealth's guide also explains how doctors and coders can "recapture" as many prior health conditions as possible. Things like fractures that have healed will fall off, but chronic conditions are expected to carry over. The assumption is that as people get older, they will have more diseases.

"There are a lot of targets that are just set to meet some obvious financial endpoint. They were unrealistic," the former WellMed physician said. "People like me didn't feel comfortable that these targets are the ones that we are getting our bonus based on, or people will even chase you and get you out of the company if you're not producing like other physicians."

UnitedHealth's coding book attempts to help people determine if conditions are appropriately documented. All they have to do is remember this mnemonic device: treatment, assessment, monitor, plan, evaluation, and referral — or TAMPER.

Sharon Maloney holds a photograph of her husband, Bill Sullo, who died in February 2023. *Tim Tai for STAT*

Hundreds of people across the country have taken to Yelp and Google to gripe about longer waits for appointments and doctors quitting after UnitedHealth assumed control of their clinics. It became tough to

get a real person on the phone, even after waiting for hours on hold. Billing mistakes became more common and difficult to resolve. Appointments felt rushed.

At the Polyclinic in Seattle, patient Todd Anderson said that after UnitedHealth took over, it became clear the company was trying to cut costs in every way possible. Check-in became centralized in a way that created a lot of confusion. Then came easily avoidable mistakes. The clinic sent the Seattle retiree's bill to the wrong health insurer, so it was rejected. Despite Polyclinic's repeated promises to fix the problem, Anderson was sent to collections. Then he was told if he wanted to stay on as a patient, he'd have to switch from his Aetna Medicare Advantage plan to a UnitedHealthcare one.

"Things changed rather dramatically, and it was pretty visible," Anderson said.

For some patients, waiting longer to be seen had serious consequences. Connecticut resident Sharon Maloney believes her husband might still be alive if he'd been able to see his doctor right away, as he'd been able to before UnitedHealth took over ProHealth Physicians in 2015. In the past, she said, ProHealth had reserved time for sick patients to be seen the same day.

Maloney's husband had several health issues, and he was taking medications for ulcerative colitis, chronic inflammation of the large intestine or rectum, that made him more susceptible to infections. In October of 2022, Maloney's husband had all the telltale signs of a UTI, but ProHealth couldn't get him in for three days. The day after he called ProHealth, his symptoms got so bad, Maloney took him to the hospital. By then, the infection had spread into his kidneys, leading to sepsis, antibiotics, a hospital-acquired infection, and, ultimately, his death last year.

"If he had been able to get a visit that day, if they had been able to identify the culture, and if they had gotten him on the antibiotic in the first couple of days, this slope would not have even started," Maloney said.

UnitedHealth didn't respond to questions about the care of Maloney's husband.

Former longtime Polyclinic patient Mary Woodbery said things that used to be simple now require a maze of specialist referrals and seemingly unnecessary tests. One time, her teenage son had a tiny cyst on his neck that she suspected was an ingrown hair. Instead of letting him see a dermatologist straight away, The Polyclinic first made him see a radiologist who performed an ultrasound and then a neck specialist. Finally, a dermatologist confirmed it was an ingrown hair. Woodbery was exasperated.

"They have answers. They just don't want to give them to you because they want to drag you through this endless chain of referrals so they can make sure all their departments are utilized," said Woodbery, a speechwriter living in Seattle who had seen the same Polyclinic doctor for over two decades before that doctor left.

UnitedHealth continues to absorb medical groups, including a contentious battle over The Corvallis Clinic in Oregon. Regret is starting to set in for some physicians who took UnitedHealth's offer. The coding dictates became too much for many to handle. For one former ProHealth physician in

Connecticut, remorse builds even more after hearing from longtime patients who are wondering why they can't get an appointment or why they have been mistakenly billed.

"Everybody thinks it was a catastrophe," the former ProHealth physician said. "They destroyed our practice."

STORY CREDITS

Writing: Bob Herman and Tara Bannow
Reporting: Bob Herman, Tara Bannow, Casey Ross, Lizzy Lawrence
Editing: Zachary Tracer
Graphics: Emory Parker and Alex Hogan
Illustrations: Natsumi Chikayasu
Video: Hyacinth Empinado
Art and Photo Direction: Alissa Ambrose
Additional photo editing: Crystal Milner
Copy editing: Karen Pennar, Sarah Todd
Additional editing: Gideon Gil, Rick Berke
Design and development: Jennifer Keefe, Julia Bujalski, Ben Lokshin

About the Authors

Bob Herman

Business of Health Care Reporter

Bob Herman covers health insurance, government programs, hospitals, physicians, and other providers — reporting on how money influences those businesses and shapes what we all pay for care. He is also the author of the Health Care Inc. newsletter.

bob.herman@statnews.com
@bobjherman

Tara Bannow

Hospitals and Insurance Reporter

Tara Bannow covers hospitals, providers, and insurers.

tara.bannow@statnews.com
@TaraBannow

Casey Ross

National Technology Correspondent

Casey Ross covers the use of artificial intelligence in medicine and its underlying questions of safety, fairness, and privacy.

casey.ross@statnews.com
@caseymross

Lizzy Lawrence

FDA Reporter

Lizzy Lawrence leads STAT's coverage of the Food and Drug Administration. She was previously a medical devices reporter.

lizzy.lawrence@statnews.com
@LizzyLaw_

To submit a correction request, please visit our Contact Us page.